DOCUMENT RESUME

ED 155 369 CE 016 632

TITLE The Education and Training of Public Health Medical Officers. Report on a Working Group. (Copenhagen, Denmark, February 23-25, 1976)
INSTITUTION World Health Organization, Copenagen (Denmark). Regional Office for Europe.
REPORT NO ICP/HMD-037
PUB DATE 77
NOTE 34p.

EDRS PRICE MF-$0.83 HC-$2.06 Plus Postage.
DESCRIPTORS *Administration; Administrative Problems; *Educational Needs; *Educational Programs; Foreign Countries; Health Education; *Health Personnel; Job Skills; *Program Evaluation; Program Improvement; Public Health
IDENTIFIERS Europe; *Public Health Medical Officer

ABSTRACT

A group of directors of schools of public health and health administrators convened to discuss the administrative problems involved in the education and training of public health medical officers (PHMO) in the World Health Organization (WHO). Their two main purposes were (1) to specify the needs for, and patterns of medical officers of health and to discuss possible training programs which would be closely relevant to their expected functions; and (2) to orientate the long-term program of the Regional Office more towards the education and training needs of those engaged in public health services, as well as towards WHO country health planning projects dealing with health manpower development in relation to all categories of health personnel. The working group set out to review PHMO training programs in a number of European countries. The following elements were analyzed: differences due to sociopolitical influences; the socio-economic situation and its implications for the functions of the PHMO; the functions of the PHMO; and recruitment difficulties. The group also identified difficulties and prevailing tendencies of the programs by focusing on the following aspects: present developments; content of training (skills); role of research in training; senior staff training for leadership; and educational policy and planning. Finally, in considering how the Regional Office could best promote public health education, the group reviewed various types of schools of public health and studied the relationship between schools and health administration. The meeting concluded with a summarizing of the most important factors and implications. (BM)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED155369

The Education and Training of Public Health Medical Officers

Report on a Working Group

Copenhagen
23–25 February 1976

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

A. Ezban

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM."

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

OE 016 632

Not for Sale
Distributed by the
REGIONAL OFFICE FOR EUROPE
World Health Organization
COPENHAGEN
1977

2

ICP/HMD 037

Note

This report has been prepared by the Regional Office for Europe of the World Health Organization for governments of Member States in the Region and for those who participated in the Working Group on the Education and Training of Public Health Medical Officers. A limited number of copies are available to persons officially or professionally concerned in this field of study from the WHO Regional Office for Europe, Scherfigsvej 8, 2100 Copenhagen Ø, Denmark.

The views expressed are those of the participants in the Working Group and do not necessarily represent the decisions or the stated policy of the World Health Organization.

The designations employed and the presentation of the material in this report do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Where the designation "country or area" appears in the heading of tables, it covers countries, territories, cities or areas.

This report is also available in French and Russian.

CONTENTS

		Page
1.	Introduction	5
2.	The situation of the public health medical officer	6
	2.1 Differences due to sociopolitical influences	6
	2.2 The socioeconomic situation and its implications for the functions of the PHMO	8
	2.3 The functions of the PHMO	9
	2.4 Recruitment difficulties	11
3.	Training programmes and developments	13
	3.1 Present developments	13
	3.2 Content of training (skills)	17
	3.3 Role of research in training	19
	3.4 Senior staff training for leadership	20
	3.5 Educational policy and planning	21
4.	Training institutions and public health administrations	22
	4.1 The various types of schools of public health	22
	4.2 The relation between schools and health administrations	25
5.	Summary	28
Annex I	Agenda	32
Annex II	List of participants	33

1. INTRODUCTION

The Working Group was convened to discuss the education and training of public health medical officers in the WHO European Region. Both WHO headquarters and the Regional Office for Europe had considered problems of training for public health services at previous meetings. However, a number of new developments had led the Regional Office to convene a group of directors of schools of public health and health administrators to discuss the many educational and health administrative aspects of the problem.

The two main purposes of the meeting were:

(1) to specify the needs for, and patterns of work of, medical officers of health and to discuss possible training programmes which would be closely relevant to their expected functions;

(2) to orientate the long-term programme of the Regional Office more towards the education and training needs of those engaged in public health services, as well as towards WHO country health planning projects dealing with health manpower development in relation to all categories of health personnel.

The planning, provision and evaluation of health services need well-trained medical officers, especially at the senior level. To identify common strategies in training it would be necessary to include in the discussions not only health administrators, but also those who formulated educational policy.

Against this background and these objectives, the Regional Director, Dr Leo A. Kaprio, welcomed the participants and outlined the situation facing countries in Europe as regards the training of public health medical officers (PHMOs). He thanked the Austrian Government for making the meeting possible by providing funds on a voluntary basis.

Some countries had developed training programmes which were fully geared to the functions and the role of the PHMO. Examples were the training schemes for community health officers in the United Kingdom and for health organizers in the USSR. Other countries were planning to adjust their training to the new tasks which had been added to the more traditional ones and were still not quite certain of the direction their programmes should take.

The meeting was concerned not with the top-level public health administrator but with the senior public health medical officer who administered services at the municipal area or regional level. His services consisted sometimes of health and medical services and sometimes of public health services only.

A list of reports on previous WHO activities in the field of education and training in public health had been prepared for the meeting. Two reports were specifically mentioned, namely, the Report of a WHO Expert Committee on Postgraduate Education and Training in Public Health (WHO Technical Report Series, No. 533), and the Summary Report on a Working Group on Specific Problems of Schools of Public Health (ICP/HMD 020(S)), which deal with the responses of public health educators to the new needs of health administrators.

The Working Group set out to review the situation with regard to the training of public health medical officers in a number of countries representative of the European Region, to identify associated difficulties and prevailing tendencies, and to consider how the Regional Office could best promote public health education in both its medium-term programme of health manpower development and in its programmes of assistance to Member States.

The Regional Director agreed to act as Chairman for the meeting, and Dr A.C. Eberwein was appointed Rapporteur. The agenda and the list of participants are given in Annexes I and II respectively.

2. THE SITUATION OF THE PUBLIC HEALTH MEDICAL OFFICER

2.1 Differences due to sociopolitical influences

While the problems being caused by changes in the biological and physical environments and the demands resulting from medical and technological advances and social pressures are common to all European countries, there is much variation in the structure, forms of delivery, and availability of health services. Some are comprehensive, centrally planned systems with varying degrees of decentralization of management at intermediate and local levels. There is no set pattern, and the recent reform in the United Kingdom, particularly at the area and district levels, underlines this situation. There are different points of entry into such a system, with different patterns of organization and demands on resources, but it has the advantage of being a total system which can be managed as an entity. Its hospital, primary care and public health subsystems can be closely associated; this facilitates their operation and assures individuals and communities easy access.

Peripheral health services, as distinct from personal services, can either be attached to a peripheral health establishment providing different types of services or be an entity in themselves. The public health medical officer at central and intermediate level is the chief planner, whereas at the local

level he is chief organizer and manager. The typical basic public health services are provided through a special network, e.g., sanepid stations, or delegated to other administrative bodies, e.g., communes. The health centre has become an increasingly important form of delivering curative and preventive personal health services. Its corresponding form in certain countries is the ambulatorium.

In other countries, where "liberal" systems of health and medical care exist, the various elements of services have varying degrees of independence. Responsibility for planning, implementing and evaluating a particular part of the services may be delegated to groups outside the governmental structure. This applies to the hospital system at community, district or regional level and, as far as ambulatory medical care is concerned, to the professional organizations of physicians and/or associations of physicians working for particular health insurance systems. The central government authority retains only a general supervisory role with regard to the legality of the policy of these bodies. These services may be only loosely coordinated and difficulties may arise as a result. There is at present much discussion and critical analysis of this situation in certain countries, particularly in western Europe. A feature of this situation is that the public health service has retained the responsibility for a number of environmental health tasks, the control of communicable diseases, together with some form of control of health and related establishments. Other tasks such as the registration of health personnel, preventive measures for at-risk groups, and the provision of medical expertise for social insurances and social welfare agencies, vary widely in these "liberal" systems. The sociopolitical environment in which a PHMO functions is of basic importance and it is evident that each country must consider those functions and, if necessary, review them in the light of its own administrative system.

There are certain aspects of this situation which have gradually developed and which should be noted. Whereas previously there was a close association between the general tasks and responsibilities of a local or district health officer and those of the general practitioner (whereby a general practitioner exercised all the functions of a "local" public health officer), this type of dual function has ceased to exist in most countries. On the other hand, whereas a number of specialized functions in the preventive personal health services provided by the public health authorities later became the responsibility of public health medical officers, in certain situations some specialized activities in the field of preventive health care are now carried out by general practitioners on a part-time basis. Whatever their advantages or disadvantages, the fact remains that in "liberal" systems coordination at the basic level is possible, difficult as this may be. More sophisticated and economically stronger sickness insurance systems have now increased the availability of preventive services on demand for a variety of at-risk groups. How much (or how little) people take advantage of these services, and

how much follow-up, evaluation and feedback can be provided through the system of services rendered by general practitioners, it is difficult to say and not of main concern in this context.

2.2 The socioeconomic situation and its implications for the functions of the PHMO

It is evident that the changes in the role of the PHMO can be seen only against the background of a variety of factors which have been instrumental in bringing about those changes. It is clear that the role of the PHMO has now reached an important turning point in its development. Not only are expectations and demands growing among those for whose benefit the services are provided, but also people are becoming more conscious of and knowledgeable about their perceived needs. On the other hand, health services throughout Europe are absorbing an ever-increasing percentage of the available financial and manpower resources. The PHMO's role is influenced by these and other factors, although the political decision-maker and lower echelon administrator is most directly concerned with this situation. However, the technical and professional considerations are largely entrusted to the PHMO, inasmuch as he has to be able to consider alternatives for the future, and plan and evaluate the present services.

The members of the Working Group singled out a number of these factors which, in effect, have a profound influence on society in general and on health and medical services in particular. Most important is the fact that they closely affect the functions of the PHMO, since he is concerned with the health of people in all its aspects. The following factors of modern life were felt to be of particular importance in this connexion:

(1) progress in medical science and technology;

(2) the changing disease pattern;

(3) the changing demographic picture ("aging" of the population);

(4) a growing awareness of the need to apply health economics;

(5) the impact of modern civilization (e.g., industrialization, urbanization, with all their ecological and social results);

(6) the growing health consciousness of individuals and the societal implications of the resulting increased demand.

During the discussion the subject of "consumer participation" was raised. Obviously, when one is considering public administrations which are part of

the governmental structure in the wider sense, the consumer is indirectly participating through the elected bodies and those appointed by them. However, mention was made of one country where the decision-making is indeed in the hands of the consumer and where the health assembly of the community itself decides about programmes and the allocation of resources.

The political importance given to health does not always correspond with what the public demands. Furthermore, there are certain inequalities, e.g., maldistribution of resources among different geographical areas and different social groups, which make it necessary for a PHMO to be well equipped to correct such situations by careful planning. Health education facilities and the mass media can well be used to orientate consumer interest and participation in the right direction.

District health councils in which consumer and other groups are represented were cited as one of the factors closely influencing the orientation and scope of work of the PHMO. Stated health policies by governments often reflect these changes. For instance, as a result of socioeconomic developments the health policy of one country is being profoundly reshaped from a policy of sickness-oriented care to one of health promotion.

2.3 The functions of the PHMO

The tasks of a chief public health medical officer at local or intermediate level vary according to the form of system in which he is functioning. In integrated or unified health systems all medical and health services are the concern of the public health administration and its senior medical officers. As regards other systems, in which hospitals and primary care are not the direct responsibility of local and intermediate government, the need for senior medical public health officers has been questioned. The Group firmly believed that there was a definite need for senior medically qualified administrators with leadership functions, particularly in such systems in district, regional and central positions.

The involvement of a number of governmental bodies in the administration of health and related services at central level calls for the coordinating function of a PHMO at local level. Furthermore, public interest in "health" nowadays generates concern about health problems well beyond the scope of traditional public health, and such problems are best dealt with by medically qualified health officers.

Three "typical" systems may be said to exist, in which the PHMO functions:

(1) a unified service;

(2) a service in which preventive and curative functions are separated, with the PHMO responsible only for environmental health, control of

communicable diseases, inspection of health and related establishments, and possibly registration of health personnel;

(3) a service where, in addition to "traditional" tasks, the PHMO exercises some functions in the field of preventive health services, as medical adviser to social insurance and social welfare agencies, etc.

The role of the PHMO varies considerably from one country to another with regard to responsibility for administrative decisions, expert competence and team management. France provides a clear example of services managed by nonmedical administrators, each assisted by a limited number of medical inspectors. Another example is the USSR, where the senior public health medical officer is not only the manager but also forms part of the political decision-making body, and therefore participates in decisions concerning programmes, priorities and allocation of funds.

Following the recent reorganization in the United Kingdom, all health services are administered and operated as an entity. The district community physician is a member of a team which manages, by consensus, all community health matters, and is kept informed about the views of the consumers by community health councils.

In Belgium, the "médecin hygiéniste", at the local and municipal levels, has a largely advisory role. Nonmedical staff are employed for specialized tasks, particularly in environmental health, where the techniques are not within the competence of medically trained hygienists.

In Sweden and Denmark, the "traditional" tasks are still the main preoccupation of the community medical officer.

In the Federal Republic of Germany, PHMOs feel dissatisfied because general practitioners have taken over some of the preventive tasks which were formerly an important part of their own work.

The division of responsibility for various parts of the health services among different bodies, particularly in "liberal" systems, has tended to remove from the PHMO responsibility for medical tasks; accordingly, it has been suggested that it wouuld be more appropriate to appoint nonmedical health administrators, who would be assisted in their expert capacities by public health medical officers and other specialists.

The Group did not consider such an arrangement to be compatible with the needs and expectations of the community. Irrespective of the type of system, there must be a focal point where an overall view of the health situation can be taken and presented to the political decision-making body, and where alternative solutions and priorities are proposed. This is a strategic function of the PHMO and probably the most important argument in favour of his existence. Political leaders and senior administrators must see that provision is made for health needs and consumer demand and society has the right and the responsibility to see that the services are provided by

professionally qualified public health medical officers whose training equips them to regard, as the focus of their professional responsibility, human-beings, both individually and as a community.

This potential of the PHMO, whether realized or not, has important implications for public health education. The following points are a summary of the Group's views on the functions of the PHMO.

(1) Traditional public health practice will continue to occupy an important place, with a tendency for specialization, and with certain functions being performed by other professionals such as engineers, pharmacists, biologists and physicists.

(2) In a very few countries the PHMO functions only as an adviser to the administrative authority on hygiene, the control of communicable diseases, inspection and control of medical and health establishments and similar and related tasks (sometimes referred to as the "traditional" tasks).

(3) In only a few countries is the PHMO entrusted with the management of all the health and medical care services of the community.

(4) The range and mix of executive and advisory functions differ widely.

(5) It is clear that administrative (including legal) structures lack the capacity to respond quickly enough to changing community needs, and this discrepancy appears to be increasing in some places.

(6) In some countries, the lower level of administration has limited contact with and restricted access to the political authority.

(7) Subspecialization appears to increase the effectiveness of the health team in certain situations, but in others it seems to fragment services and thus to weaken the position of the PHMO.

(8) The PHMO has little time for "global" or "strategic" thinking, being almost exclusively absorbed by routine activities.

(9) It is important to bridge the gap in understanding and communication between politicians, administrators and the medical profession.

2.4 Recruitment difficulties

The position with regard to the recruitment of young doctors to public health posts varies considerably throughout Europe. In some countries there are no recruitment problems, while in others, the proportion of unfilled positions is alarming.

The countries which have no manpower problems are exclusively those with unified health and medical care systems; in the others there is a considerable lack of personnel. Remuneration is not necessarily the most important factor, but in countries where public health medical officers are in short supply and medical graduates show no interest in public health careers, the difference between the salaries of public health physicians and others is so great that it must be a major factor. A significant improvement cannot be expected as long as medically qualified staff are paid on the same salary scales as other professional categories in public services. In countries with unified nationalized services, the salaries of senior PHMOs compare favourably with those of the medical staff in other branches of the services.

Other factors besides remuneration affect recruitment. One is the public image of the PHMO and, even more important, how he is perceived by the medical profession and medical students. Examples were cited of chief PHMOs who, because of their high standards of professional and personal competence, attracted recruits even in unpromising circumstances.

The influence which undergraduate teaching has in introducing medical students systematically to the various disciplines of public health (e.g., epidemiology, social medicine, the organization of health services) is certainly important. For several years now there has been an increasing trend to assign a proper place in the undergraduate curriculum to these disciplines. At the same time, students should also be given an opportunity to gain practical experience in these disciplines. Any medical curriculum which is too restrictive with regard to public health will not encourage students and young graduates to accept careers as PHMOs.

Another related factor is that public health is not a recognized discipline, it lacks a clearly defined area of research and depends not infrequently on nonmedical disciplines to develop research methodologies. Health services research, which is slowly gaining momentum in Europe, is not yet accessible to medical students, whereas in contrast they can see immediately the implications of clinical research. If health services research in an academic environment is almost nonexistent, it is not difficult to understand why young graduates show only slight interest in a field where there is little or no scientific recognition.

The Working Group was told that one country was attempting to improve the situation by providing fellowships for undergraduate medical education and modifying admission requirements for candidates who undertook to work in public health.

The recruitment situation is an important barometer of the state of public health services in general and of the situation with regard to the public health medical officer in particular. The PHMO should command respect from the public at large, the medical profession, the scientist and the administrator. If that were generally the case, many recruitment difficulties would be resolved.

3. TRAINING PROGRAMMES AND DEVELOPMENTS

3.1 Present developments

There is now a trend to recognize public health as a specialty and to accord specialist status to the PHMO. In the USSR and the other eastern European countries, public health in general (organization of health services) as well as certain other related disciplines are recognized as medical specialties for which qualifications are obtained at various levels of postgraduate training. Recently community medicine has become recognized as a specialty in the United Kingdom. The Faculty of Community Medicine of the Royal Colleges of Physicians of the United Kingdom, established in 1972, is the Specialist Advisory Committee for specialist training in community medicine of the Joint Committee on Higher Medical Training of the Royal Colleges of Physicians, and is represented on the Councils for Postgraduate Medical Education for England and Wales, Scotland and Northern Ireland. Membership of the Faculty, obtained by examination, is becoming the recognized academic specialist qualification. In Ireland there is a similar development, with the establishment of a Faculty of Community Medicine of the Royal College of Physicians of Ireland.

In the Federal Republic of Germany, two *Laender* now recognize public health as a specialty (on the basis of fulfilments of all conditions of the *Staatsärztliche Prüfung*[a]). The other *Laender* are expected to follow.

In other countries diplomas are awarded by universities or by the State. In some there are no academic qualifications nor, as in Sweden, can public health be recognized as a specialty, although formal training is provided there and attendance at a prescribed course is a requirement for appointment to posts of county public health officers.

The members of the Working Group then described the situation in their respective countries. These descriptions are summarized below.

In the USSR, postgraduate training in public health is provided at three levels: (1) the oblast (region with 2–5 million inhabitants) with one or more undergraduate medical schools and an institute for postgraduate training, which includes public health training for medical officers; (2) the republics, where institutes for advanced studies train public health officers for higher responsibilities, and (3) the Central Institute for Advanced Medical Studies,

[a] "State-medical examination", i.e., an examination, conducted by the State, for those who have fulfilled a number of conditions. Successful candidates are appointed to the posts of Chief Public Health Officer *(Amtsarzt)* or Deputy Public Health Officer in districts or larger municipalities.

Moscow, which, in particular, trains teachers for the institutes mentioned above, and also senior administrators (e.g. deputy ministers). A certificate attesting to the successful completion of a course of advanced studies in public health administration is awarded, this being a requirement for a number of posts of senior public health medical officers.[a]

In the United Kingdom, with the recent reorganization of the national health service, the former statutory post of medical officer of health has been replaced by that of the community physician, who has a much wider role in the administration of all health services. Education and training for the new specialty of community medicine[b] is being regulated by the Faculty of Community Medicine of the Royal Colleges of Physicians of the United Kingdom. After medical graduation and one year working as a hospital house officer there is a period of general professional training lasting up to three years (first stage). The second stage is that of "early specialist training" which may last 1–2 years, and the third stage is that of higher specialization, lasting about three years. These programmes reflect the general and specialized functions of community physicians at various levels and in leadership positions. Fig. 1 summarizes the situation in the United Kingdom and shows that specialist training in community medicine is comparable to that in clinical specialties.

Consortia have been formed to provide the necessary periods ("modules") of teaching and the practical work for stage 1 of the specialist training. The London School of Hygiene and Tropical Medicine has established a Centre for Extension Education and gives special courses which rectify existing deficiencies.

In Belgium there are three different levels of public health medical officers, each having various functions and responsibilities. At present six

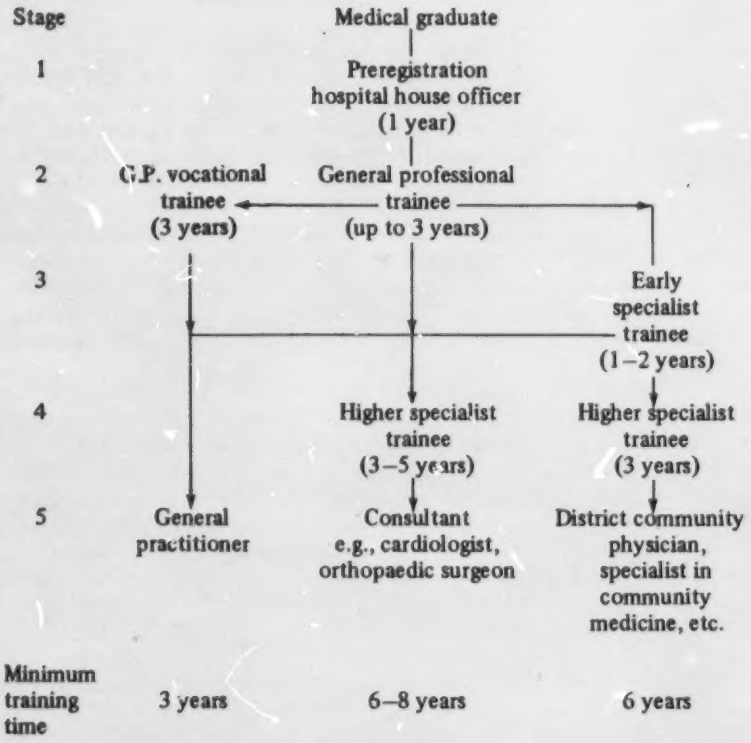
---

[a] For more details see: World Health Organization. *World Directory of Schools of Public Health, 1971*. Geneva, 1972

[b] "The term 'community medicine' refers to that specialty of medicine which is concerned with the health of populations or groups of people rather than the clinical care of individual patients. The practice of community medicine incorporates the study of the distribution of mortality and morbidity in the community, the determination of the needs for preventive and medical care services and the allocation of health service resources to meet those needs.

Community medicine, like clinical medicine, has a number of subspecialties. Individuals practising community medicine include experts in health services administration (medical administration), epidemiology, medical information systems, communicable disease control, environmental medicine, nonclinical aspects of occupational medicine, and health education, or a combination of two or more of these." – Faculty of Community Medicine, Royal Colleges of Physicians of the United Kingdom. Specialist training in community medicine. November 1974.

Fig. 1. Specialist training



Note: Stage 2 – General professional training

Stage 3 – Early specialist training (up to at least Part 1 of the MFCM).

Stage 4 – Higher specialist training (completion of MFCM and further experience).

Stage 5 – Accreditation (Joint Committee for Higher Medical Training).

universities provide training in public health. The diploma course for public health medical officers *(médecin hygiéniste)* lasts one academic year. The diploma of *médecin hygiéniste* is required for posts connected with various public health activities, such as public health administration, school hygiene, occupational health, etc. Obviously in the context of this meeting it was the aspect of public health administration that was of primary concern.

In Sweden, the public health training given by the Scandinavian School of Public Health in Gothenburg is in the process of reorganization. No diploma is given by the School, nor is a special examination held. The course is considered equivalent to a diploma course in public health and is a formal requirement for county public health officers. The objectives of the courses, in line with the Government's health policy, are being redefined. The total length of medical education in Sweden is 5½ years to which should be added another 1–1/3 years of supervised training as *underlage* (assistant), this period ending with a written examination. After this a licence to practise is conferred and the doctor has the choice of either going into general practice as a district doctor or proceeding to clinical specialization (3½ years on average).

According to the plans, 1½ years of work in health administration plus a three-week introductory course are necessary for those seeking to become public health medical officers; after this, candidates will be appointed to posts as junior county public health officers. Only a limited number need to be trained and it is considered sufficient to have five places for postgraduate training available yearly so as to provide the country with senior public health medical officers. Postgraduate courses of six months' duration for occupational health physicians are conducted by the National Board of Occupational Health and Medicine; the participants should already have had 3½ years' specialization in medicine.

With regard to Denmark, the meeting was told that a working group had been set up to consider the further development of training schemes.

The situation in France, where recruitment has also become a difficult problem for the health administration, was described. There are basically two ways of entering a public health career: either through a competitive entrance examination *(concours)*, or by fulfilling one of the following conditions.

(1) degree as medical doctor with two years' experience in general practice, plus a diploma in public health (National School of Public Health, Rennes); or a certificate in hygiene (university) with one year's experience in teaching related to theory and practice in this field; or a diploma in advanced studies in public health *(diplôme des hautes études en santé publique)*; or a certificate in medical statistics or microbiology;

(2) as a registrar *(assistant chef de clinique)* or after four years of internship in a teaching hospital; (this necessitates participation in the competitive examination);

(3) experience as a contractual physician in a public health field (school health, maternal and child health, etc.).

As far as the competitive examination is concerned, out of the 60 vacancies available last year only six could be filled. As regards training programmes, the more "modern" subjects, such as epidemiology, information science and operational research are well represented.

In the Federal Republic of Germany, the former five months' course has been extended to six months and is being modernized. However, the main concern is not only to provide a general public health course for those subsequently occupying senior positions as public health medical administrators, but to make it a basic postgraduate course for all those working in public health, either in specialties such as maternal and child health and mental health, or in general public health. A concept is now being studied according to which training would be provided in three parts: a basic introductory part (a number of "core" courses), a second more specialized part and, after a number of years of active service and experience in public health (the minimum proposed is 3–5 years) two advanced courses (each of 1½ months' duration) with an interval of one year between them, during which some research work should be performed. This latter part of the training would be required only for those who would be eligible for leading positions at district, regional and possibly central levels.

3.2 Content of training (skills)

The Working Group found it difficult to compare training in different countries, as far as content was concerned. Various attempts were made to find basic common factors. In general, it was found that periods of academic training alternated with periods of practical training. Theoretical learning alone can no longer meet the objectives of postgraduate training. The necessary skills must be acquired by practice in settings which permit their transfer to professional practice later. Supervised learning in practical settings complements academic training; this includes work with a health team as a member of that team. In addition, it is considered that research should be part of the learning process.

It appears that the programmes offered by schools of public health in most countries of Europe no longer take the form of a single fixed curriculum, though the Federal Republic of Germany, Austria and Sweden are, by and large still doing so. There was instead some diversity of programmes, which reflected the increasing complexity of public health practice. It is no longer within the capacity of an all-purpose public health medical officer, but needs a group of specialists, all of whom require postgraduate training. The ways in which this is being achieved in the programmes of the various schools differ widely.

The Group considered that a postgraduate institution should provide:

(1) general training and an introduction to the theory and practice of public health for all medical staff working in public health;

(2) an appropriate amount of specialization and further training for the generalist (as a continuation and/or extension of the first part of the training); and

(3) through subsequent training, advanced programmes for senior personnel which might include training for a small number of specialists (particularly in teaching and research) as well as for senior generalists.

The Group was at that stage largely concerned to hear what kind of programmes were actually offered or were considered necessary. Three broad types of curricula or components of curricula very similar to those described at a previous WHO meeting,[a] were identified.

(1) the more traditional one (with hygiene, public health law, communicable disease control, vital statistics and epidemiology still playing an important role and the PHMO being considered an "all-purpose man");

(2) the sociomedical one (some important components of which were added long ago and some of which are still being added (maternal and child health, school health, chronic diseases, services for the handicapped, screening, etc., with the PHMO becoming an administrator);

(3) the "modern" one (with the PHMO becoming in large measure, a party to a multidisciplinary endeavour involving planners, sociologists and economists).

In general terms, postgraduate students should acquire a knowledge of health systems, and learn analytical, quantitative, behavioural and political skills.

Specific fields included: information science (including statistics and demography); epidemiology; hygiene and environmental health; ecological sciences; management sciences; planning and evaluation of services; health

[a] WHO Technical Report Series, No. 533, 1973 (*Postgraduate education and training in public health*: report of a WHO Expert Committee)

operations research and systems analysis; microbiology, including communicable disease control; pharmacology as related to public health; health education (psychosocial sciences); social medicine; various areas of personal health services, such as maternal and child health, school health, mental health, handicapping defects, chronic diseases, old age, etc. This is by no means an exhaustive list, but represents the more important areas of knowledge and competence which the PHMO needs to fulfil his functions at the present time.

3.3 Role of research in training

The concept that those who teach at postgraduate level should perform research is to some extent part of the educational and staff policy of the training institution. The Group discussed various aspects of research in the context of training. It is important for the future PHMO to realize that, in the planning, operation and evaluation of health services, not only facts (information) determine policy and practices; research on health services is not infrequently needed too, and this element is of particular importance in the planning stage when problems of procedure or of substance have not been sufficiently explored.

It is therefore being increasingly recognized that at a certain stage in the training process, the trainee should carry out research work, either with the staff of his institute or as part of his field training. The purposes of such an approach are the following:

(1) that the trainee should become fully capable of using techniques, methods and skills to which he has been introduced during his formal teaching (e.g. epidemiological methods, statistical techniques, operational research, systems analysis, cost/benefit analyses, etc.); he will then become aware not only of the possibilities, but also of the limits of these methods when applied in specific situations;

(2) that the trainee, particularly at a more advanced stage in his training, should be able to produce solutions which may be helpful in the further development of a programme in given situations.

(3) that the trainee should have the opportunity to experience a multidisciplinary effort in solving problems.

These three aspects have evolved during recent years, and are in marked contrast to the situation that hitherto obtained (and that still exists in some countries), whereby a candidate had to prove that he himself, without the assistance of others, was able to examine a problem, and provide proposals for its solution, either on the basis of a study of the existing literature or on the basis of his own observations or information collected by himself.

3.4 Senior staff training for leadership

The importance of this area was underlined in the discussions. The Regional Director informed the Group that training for leadership positions, particularly at the national level, would be the subject of special consideration at a later meeting.

While various methods are applied by countries in providing in-service training or refresher courses for those who occupy positions of leadership, such persons nevertheless have to learn a great deal from their own experience. They will have to be given opportunities to discuss among themselves the problems encountered, to analyse them and draw conclusions from them. Such exercises, which, because of the pressures of daily work, can only be of short duration, should be held in an atmosphere conducive to achieving their purpose. As the top senior official is the direct adviser to the political decision-maker he will have problems that are directly or closely related to those of his colleagues in other departments. It is therefore also important to have top leadership training arranged on a "multidisciplinary", i.e., an interdepartmental, basis. This is, in fact, already the practice of some governments. It is essential that this exchange of experience on common problems should take place not only at a national, but also on a multinational basis, i.e., in informal meetings, and discussions with colleagues from neighbouring countries and/or countries having similar problems. Such meetings should be kept well apart from official meetings of international organizations, where the procedure and topics of discussion will normally be predetermined to a large extent.

While leadership training is an important factor in keeping the very senior staff of central health administrations aware and up to date in their particular fields of activity, advanced training for those who will be active in the scientific teaching sides of the health services is of equal importance. This in turn, has a certain impact on the training of the PHMO. However, organized and structured advanced scientific training is at present available in a limited number of countries only. Although a doctorate of public health was established in the United States as long ago as 1912, only in recent years has higher training in public health been introduced in some schools of public health in Europe. The Master of Science course in social medicine at the London School of Hygiene and Tropical Medicine lasts two years, the aim being "to provide a common postgraduate training for doctors wishing to specialize in social medicine and follow careers either in medical administration or in research and teaching. The course is designed for persons who hold a medical qualification and have a good clinical experience". The School of Public Health of the Free University of Brussels has instituted studies for a doctorate in public health which is based primarily on a substantial piece of research work lasting 2–3 years. According to available information, the National School of Public Health in Rennes, France, has also initiated an

advanced programme in public health studies, based mainly on original research work in public health and leading to a doctorate degree. In the USSR, as in most of the eastern European countries, postgraduate training has been systematically structured and is being provided by the postgraduate training institutes. This has for a long time helped to establish public health subjects as scientific disciplines in which higher academic degrees such as "candidature" and "doctorate" can be awarded.

Whatever might be the specific characteristics and objectives of these various advanced programmes, some common factors may be identified: firstly, previous training in public health is no longer considered sufficient; secondly, it is evident that the stimulus for advanced training has come chiefly from the academic side; thirdly, the advanced academic programmes are based mainly on research work, which is important in helping to enhance the competence of "academic leaders".

It is evident that leadership refresher training and advanced scientific training have little in common in their form or, largely, in their content, but both are important aspects for strengthening the basis of the senior public health medical officer's actions and thinking.

3.5 Educational policy and planning

The Group did not enter into a systematic discussion of educational policy and planning. However, it was considered important for the training process that the functions and tasks of the PHMO be identified and analysed, educational objectives derived accordingly and educational resources developed It was also felt to be important that the senior public health medical officer should himself have some understanding of educational policy and programmes, particularly of those factors inherent in his work and in that of his team which influence educational planning.

Certainly, important data on which educational planning is based have to be obtained from the services. These data will then enable teacher and student to formulate and understand educational objectives, to devise appropriate learning experiences and to help in the evaluation of the training process and of the student's performance. The data in the planning process "should be drawn from a variety of sources, including:

(a) job analyses of the actual performance of various categories of public health workers;

(b) consultations and interviews with public health practitioners, supervisors, and teaching staff who are familiar with local health care problems;

(c) demographic and epidemiological studies to document the type and frequency of health care problems, analyses of health care delivery

systems, and health development plans pertinent to the country or region in which the student will work after graduation;

(d) analysis of the student's prior training and experience and his performance in entrance examinations."[a]

The important lesson to be learned by a senior administrator from his understanding of the main principles and steps of educational planning is the fact that his services can and must contribute to the training of all health personnel, including his own, so that manpower utilization can be better analysed, understood and adjusted.

4. TRAINING INSTITUTIONS AND PUBLIC HEALTH ADMINISTRATIONS

4.1 The various types of schools of public health

In general, public health training, irrespective of the detailed meaning attached to the term "public health" in different countries, "is taken broadly to mean the postgraduate training required by health planners, administrators and personnel engaged in public health services who need such competence"[b] It is accepted that the training is given by schools of public health or similar institutions. A school of public health has been defined by a WHO Expert Committee as "an institution with adequate resources which, in addition to research in public health and service to the community, provides a full-time course lasting not less than one academic year, or its equivalent, covering the subjects essential to the understanding of the various problems of public health and the concepts, organization and techniques required for dealing with them, and which is open to members of the medical and allied professions seeking qualification in public health".[c]

In its 1973 report, the WHO Expert Committee stated: "while agreeing that the definition given in the 1961 report might be retained the Committee thought fit to state that a school of public health should be viewed as a

---

[a] WHO Technical Report Series, No. 533, 1973, p. 61

[b] WHO Technical Report Series, No. 533, 1973, p. 7

[c] WHO Technical Report Series, No. 216, 1961, pp. 4–5

functional entity whose main purpose is to provide general and specialist public health training for members of health and other professions who require it. Among the courses offered there should be a basic course leading to a postgraduate-level qualification in public health. Schools of public health may also have research responsibilities and provide direct and advisory services to the community."[a]

The Working Group did not consider schools of public health from an academic point of view, but a few factors of importance in this context were singled out, including the question of how those responsible for the management of schools and those responsible for the administration of public health could together plan and organize postgraduate training, particularly that of senior staff. The following points received attention.

4.1.1 *The organization and administration of schools of public health*

The Working Group's views on this subject corresponded closely with those expressed by the WHO Expert Committee in its 1973 report. It is therefore appropriate to reproduce here *in toto* the relevant section of that report, since it had considerable bearing on the Group's subsequent discussions.

"About one-third of the schools of public health are departments of undergraduate medical schools or colleges offering a basic postgraduate programme in public health and in some cases also courses for sanitary inspectors and other nonmedical health personnel. These schools, while in some instances enjoying a considerable measure of autonomy, are administered by the governing body of the medical school, usually a university faculty, of which they are a part.

The situation of the postgraduate schools and institutes is less uniform. Some are relatively autonomous units within a parent university. Others are governmental schools administered by the ministry of health and/or the ministry of education. Some are affiliated with a research institute, others are independent or private institutions, and a few are military colleges primarily within the jurisdiction of a government department of defence. Almost unexceptionally, however, they are in close relationship with government departments responsible for operational health services.

Although in the early years after their establishment some schools were independent of a university, there are few mature schools that are not now either within or affiliated with a university.

Typically, the governing body of the school is responsible for its administration, including the formulation of training programmes and curriculum

---

[a] WHO Technical Report Series, No. 533, 1973, p. 7

proposals, subject as a rule to an overriding control by the university authority in matters of policy, budget, academic appointments, and degree requirements. Proposals for new courses and substantial curriculum changes are commonly subject to review and approval by the university authority. The ministry of health, and not uncommonly ministries of education, planning, labour, and social security, are represented on the governing body.

Whatever their detailed character, such arrangements are usually sufficient to ensure that high academic standards are maintained and that the courses offered and levels of student intake are kept in fair alignment with service requirements and career structures."[9]

4.1.2 *Research activities*

It is commonly agreed that it is important for schools of public health to maintain research programmes. These will influence the quality of training given at the basic and specialist level, but particularly at the advanced level. "Health services research" has become an important area of investigation, which includes, for example, studies of evaluative or practical use, investigation of areas of disease prevalence, the study of utilization of services, examination of the need/demand situation in specific fields, etc. Besides the traditional epidemiological and other methods, such studies also utilize more "modern" ones, e.g., operational research and systems analysis. The Group considered research to be an important element in the qualification process and the regular activities of teachers in schools of public health.

The question whether students should participate in or carry out research work and be made familiar with research design and research techniques, and if so, to what extent, has already been dealt with in section 3.4.

4.1.3 *The use of services in the teaching/learning experience*

The value of "field experience" was emphasized by the Group. There are various ways of using field experience in the training programme and of integrating it in the candidate's progressive experience, depending on the objectives of particular stages of the training.

The simplest form is that of visits and observation; these are typical features of basic postgraduate training. The next form is the attachment, so that students can gain first-hand experience of how a job is done or how a programme is being conducted. This is also typical for the basic phase. Another step is to undertake case studies, operational studies or evaluative studies as part of an advanced programme, with the main objective of

---

[9] WHO Technichal Report Series, No. 433, 1970, pp. 55–56

obtaining a deeper insight into the service by means of research work. A more advanced step is to perform studies and research to obtain findings which can be applied by the service and which can assist in the design of special projects or in the evaluation and improvement of programmes. This may not, in general, be an educational exercise *per se*, but it is an important aspect of a school's service function. It may well be considered as a useful means of associating senior trainees with certain types of research work.

4.1.4 *The teacher and his activities in relation to the practice of public health and to undergraduate teaching*

The Group noted that teachers might well experience certain degrees of isolation. Consequently, the school's function should not be restricted to teaching and research.

Firstly, a teacher in a school of public health should have continuous contact with the practice of public health. Just as it is important for students to have field experience as part of their training, so is it essential that the teacher should work regularly (e.g. one day per week) in a service related to his field of interests and responsibilities. For instance, a small service department may be attached to the school and form part of its regular activity. Another field is that of undergraduate teaching, which gives the teacher in a school of public health another orientation and outlook. Such teaching should show students what the public health services are doing, and should not merely present public health in a theoretical way. The considerable number of part-time teachers who are widely used in public health schools helps to relate teaching to practice, but the school as an institution should, through its full-time staff, be closely linked with the services, to the benefit of both staff and students.

4.2 The relation between schools and health administrations

Some members of the Group expressed concern about the unsatisfactory nature of communication between educators and health administrators. Others felt, however, that in their particular situation there were enough mechanisms to maintain a satisfactory relationship between the educational and the service systems.

Much has already been said about this topic, and much criticism has been voiced about the lack of coordination. Nevertheless, there are numerous examples of satisfactory efforts and mechanisms of collaboration and coordination with the services. Whatever the various measures and constraints – they have been recently discussed by a Working Group convened jointly by WHO and the Association of Schools of Public Health of the European

Region[a] – it must be realized that one situation differs from another and that each country's form of organization of its services and educational system has its own legal, administrative, professional and other intricacies. However, common factors can be traced, but before referring to some of them it is appropriate to make some general points. During the above-mentioned Working Group, a working paper[b] was presented by Dr T. Fülop, in which he put forward the idea of an integrated system of health services and manpower development (HSMD). This implies a constant flow of information and feedback between the stages of planning, production and utilization of manpower and the feedback of information into the total system at each stage of this triangle. This is not a completely new approach, but it was expressed in Dr Fülop's paper in a systematized fashion. Structural elements to make this approach work do exist. The paper's author states: "the mechanism to bring about such a double integration will, of course, differ from country to country, e.g., by means of a council or committee, with or without a permanent secretariat, within which all those interested in any part of the HSMD process would be represented at the highest level. It may also take any other form, the structure being without significance; the important thing is that the mechanism functions efficiently and permanently...". Many different methods of improving coordination between various areas inside and outside the services exist. However, in addition to the above "holistic" approach, there is a more philosophical aspect to be considered, which is inherent in every analysis and synthesis of a system. Whatever system serves as a model, it necessarily has its limitations and constraints, particularly when it is to be an operational one. The reason is that every system is in some way part of another system. A further complicating factor is that it can be part of a system which may be subordinate or superimposed, or of others with which it has horizontal communicating links. The HSMD system cannot be considered in isolation from the total educational system, which itself has a number of more or less related subsystems. In fact, any systems approach needs continuous monitoring, evaluation and adaptation in the course of its operation. Just as health needs and demands undergo changes and are supposedly reflected in the training of health personnel, so the operation and management of these interdependent facets of systems need to be flexible and subject to adjustment.

If health services and training institutions are to be thought of as one entity, one must add the dimension of health services research and information

---

[a] **WHO Regional Office for Europe.** *Training manpower for health administrations:* report on the Working Group on Specific Problems of Schools of Public Health, Copenhagen, 1976.

[b] **Fülop, T.** *The health manpower process.* 1975 (unpublished document ICP/HMD 020/6)

systems in a wider sense. This implies a variety of forms of coordinating mechanisms, which again vary according to the type of national health or public health administration that has developed, what its political and social basis is and to what extent services have been nationalized and/or unified.

Another WHO meeting, held in Moscow in 1973, had as its topic: "the functions of central institutes of public health and hygiene". While it is clear that most countries have at their disposal the information provided by this type of institute, and that those institutes which do exist in Europe have considerable similarities, but also considerable differences, the area of information and research on health services needs to be brought into the cycle of services and manpower training and to play its part also in the cycle of planning/evaluation/provision/production/utilization/delivery of all activities, whether in the service or in the training field. Consultative and advisory bodies, both *ad hoc* and statutory, health information units, committees and other means are widely used, and experience shows that senior administrators, whatever their level and sphere of responsibility, have difficulties in properly feeding back the results into the service.

In this connexion, the Working Group observed that it seemed easier for educational establishments to adjust their programmes, curricula and methods of education than it was for the services to introduce changes in the organization and functioning of their areas of responsibility. Unified systems based on a common sociopolitical concept can more easily introduce changes which may be tested for long periods, whereas in pluralistic societies political changes may affect the weight and influence of certain groups, discussions and deliberations may be prolonged and previous decisions may be reversed after a change in government and political leadership has occurred.

The relationships which exist or should exist between schools of public health and health administrations were well illustrated in the descriptions given by participants of the situation in their respective countries and institutions. Satisfactory relationships are certainly more difficult to achieve if a school is part of the university structure and the educational programme for the postgraduate training of the PHMO is in the hands of the educational authorities. A strong plea was made by the Group that the needs of the services should be adequately considered by those responsible for the training of the PHMO. The administration needed to be represented on the programme committee and/or board of the school. On the other hand governments should use academics as advisers in their committees. Staff from various parts of the services are used, and should continue to be used as part-time teachers. Health services research, in which teachers, students and representatives of the services participate, is an important means of promoting useful contact and collaboration between the two sides. These and other means will be of use in bridging the gap between services and training institutions and in making the training as meaningful and realistic as possible.

5. SUMMARY

Because of the different types of administration of health services existing within various sociopolitical settings in Europe, the role and function of senior public health officers differ widely. It was agreed that the term "public health medical officer", used in the context of the meeting, would refer to a medical officer responsible for the public health services or – depending on the sociopolitical system – for all health and medical services on the lower administrative level (district, county, area, or larger municipality).

The background of the public health services and the training of the public health medical officer have to be seen in the context of the changes which have been and are occurring within the socioeconomic-ecological environment. These changes are exerting their influence on a profession which has evolved from the elements of medical tradition, the tasks of the familiar public health physician and the "modern" tasks of health administrations. The Group agreed that it was vital to consider the situation of the public health medical officer against these profound changes, which were identified as the most important factors influencing the objectives and responsibilities of the health services and, therefore, the functions of the public health medical officer himself. The following factors were emphasized:

(1) progress in medical science and techniques;

(2) the changing disease pattern;

(3) the changing demographic picture ("aging" of the population);

(4) a growing awareness of the need to apply health economics;

(5) the impact of modern civilization (e.g. industrialization, urbanization, with all their ecological and social results);

(6) the growing health consciousness of individuals and the societal consequences of the resulting increased demand.

The implications of this situation for the training of public health medical officers are considerable and educational institutions are making efforts to adjust their programmes to this situation. Those members of the Group who represented schools of public health almost invariably reported plans to modernize and reorganize training programmes. In view of the functions which the public health medical officer has to exercise and to apply to individual tasks, a number of general skills were identified which would be basic in the training programmes of today:

(1) analytical-quantitative skills,

(2) behavioural and political skills,

(3) medical skills, as well as knowledge and understanding of health systems and problems.

In particular, the following disciplines in which skills are particularly needed were emphasized: information science (statistics, epidemiology), administration (legislation), planning and evaluation (management, operational research), economics, ecology, public health aspects of pharmacotoxicology, behavioural science, health education and an understanding of educational principles and methods.

After reviewing the training programmes and methods in some detail, the Group arrived at the following conclusions.

1. The former concept of training for the public health medical officer, namely the one-time learning experience involved in following a course, is changing in a number of countries.

2. The training of the public health medical officer is being considered rather as a long-term experience consisting of a combination of supervised practical work, shorter periods of academic training and periods of research work directly related to the practical work.

3. Good practical experience in clinical work and/or general practice is increasingly regarded as a valuable basis for the preparation of the public health medical officer.

4. A modular type of training has the advantage of allowing greater flexibility and adjustment in method and content of training, and of bringing the trainee more or less continuously into contact with the service.

5. Even a modest piece of supervised research adds to the educational element and provides the trainee with the possibility of additional mental development.

6. Whereas previously a university degree or a diploma certified the successful completion of a course and was a prerequisite for public health work, there is an increasing trend to recognize public health or community medicine as a specialty, comparable with other medical disciplines.

7. The aim of continuous training can be more easily realized in an educational system where the module type of basic and specialized training

has been introduced and which is followed by refresher training, usually in short periods, but of a continuing nature.

8. The team concept and experience can be more easily promoted during supervised activities, whereas in formal training (theory) this appears to be more difficult.

Information on the types of services in which public health medical officers are working in Europe formed an important part of the background for the discussions and helped to identify the wide variations that exist. The following situations were considered as typical:

(1) the public health medical officer at the head of a unified service comprising all facets of health and medical services;

(2) a service where preventive and curative tasks are by and large separated, but where personal preventive services to a greater or lesser extent still form part of his responsibilities;

(3) a service which comprises public health activities in the restricted sense, relating mainly to environmental health, control of communicable diseases, possible registration of health personnel and sanitary control of health and related establishments.

From a consideration of these various situations it becomes evident that the way in which the public health medical officer is functioning differs widely. At one extreme he is part, not only of the administration of his area, but of the political decision-making body. At the other extreme, he is functioning largely as an expert adviser to the administration, with varying responsibilities of inspection and control. Between these two extremes there is the situation in which the public health medical officer, in the framework of stated legal and administrative provisions, fulfils an intermediate role, characterized by delegated powers of decision and by advisory functions. Inasmuch as the range of direct responsibilities and powers of action and intervention will be extended, there is, generally speaking, a basic function, namely that of the expert whose task it is to follow the development of the health situation in his area and to see that the necessary services are at the population's disposal. It was the consensus of the Group that this strategic function could be exercised only by a well-trained and experienced public health medical officer. The managerial functions of the public health medical officer, differing as they do in extent and in substance, can also be carried out by a team which, as in one country, operates through "management by consensus".

Whatever the present position of the public health medical officer, in most countries there are difficulties in interesting younger doctors in these

positions. It is only in those countries with unified systems of health services and where, at the same time, the public health medical officer is on the same level as other important specialists as regards training, responsibility and qualifications that there are fewer difficulties with recruitment. A number of reasons for these difficulties were given, including the current image of the public health medical officer, limited professional satisfaction, insufficient insight of medical undergraduates into the scientific disciplines and the components of public health services and, as a result, a diminished motivation to undertake public health work. In many countries the remuneration is considerably less than that of doctors working in general practice and clinical fields. In an attempt to overcome these difficulties, one country provides fellowships for undergraduate medical students who, during their studies, are systematically introduced to the public health services and who enter those services for a certain period of time after completing their medical studies.

The relationship between schools of public health and the health services is an important element in keeping the training as closely linked as possible to the demands for and the development of the services. Educational policies can only be developed and adjusted realistically if there is a regular analysis of the tasks. Schools are of different types: most of those in Europe are university schools, but some are either independent schools or schools dependent on the health administration. Each situation has advantages and disadvantages, but there are certain factors which are common to all:

(1) continuous dialogue between academics and public health administrators;

(2) service responsibility of academic teaching staff, which could either be advisory or take some other form;

(3) access to and contact with other university departments;

(4) the academic atmosphere and standing of the school;

(5) research as part of the school's normal activities, as a permanent component of the work of the teaching staff, and as an educational element in the training of students.

The Group stressed that the training of public health medical officers should be based on an educational policy which is the common responsibility of schools of public health and the health administration and which is dynamic in character – receptive to the changing needs of the service as well as to educational methods.

Annex I

AGENDA

1. The situation of the public health medical officer in various European countries

2. The tasks of the public health medical officer in general, particularly those of the senior group, and their specific roles at district, regional and central levels

3. The various education and training schemes for senior public health medical officers:

   (a) basic postgraduate training

   (b) specialist training

   (c) senior staff training for leadership

   (d) forms of training

   (e) the role of service components and research in the training of senior staff

   (f) the role of the training institution

4. The joint responsibility of public health services and training institutions (educational systems) in the training of the public health medical officer

5. Anticipated future developments

Annex II

LIST OF PARTICIPANTS

Temporary Advisers

Professor S. Halter, Secretary-General, Ministry of Public Health and Family Welfare, Brussels, Belgium

Dr E.J. Hopf, Chief, Department of Health, Ministry of Social Affairs, Land of Schleswig-Holstein, Kiel, Federal Republic of Germany

Dr N. Bloch Jespersen, Public Health District Officer, Horsens, Denmark

Dr J.-P. Picard, Chief Medical Inspector of Health, Assistant Regional Medical Inspector of Health, Nord – Pas de Calais, Regional Inspectorate of Health, Lille, France

Dr W. Puelacher, Chief, Kitzbühel District Office of Public Health, Kitzbühel, Tyrol, Austria

Dr I. Pustovoj, Dean, Faculty of International Health, Central Institute of Advanced Medical Studies, Moscow, USSR

Dr K.L. Rinder, Head, Division of Public Health and Primary Care, National Board of Health and Welfare, Stockholm, Sweden

Professor E.A. Sand, President, School of Public Health, Free University of Brussels, Brussels, Belgium

Dr C.E.G. Smith, Dean, London School of Hygiene and Tropical Medicine, London, United Kingdom

Professor F. Valic, Dean, Andrija Štampar School of Public Health, Zagreb, Yugoslavia

Consultant

Dr A.C. Eberwein, President, School of Public Health, Düsseldorf, Federal Republic of Germany *(Rapporteur)*

World Health Organization

Regional Office for Europe

Dr F.A. Bauhofer, Director of Health Services

Dr J. Gallagher, Regional Officer for Education and Training

Dr L.A. Kaprio, Regional Director

Dr R. Glyn Thomas, Regional Officer for Development of Community Services

Dr R. Wiedersheim, Chief, Health Manpower Development *(Secretary)*

Headquarters

Dr O.W. Christensen, Headquarters Programme Committee